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SPRINGS OF CATAWBA	2010 29TH AVENUE DRIVE NE HICKORY, NC 28601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on February 8, 2023 through February 10, 2023.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 2 sampled residents (#1) with a history of falls which resulted in injuries. The findings are: Review of the facility's accident/falls policy dated September 2021 revealed the policy did not include any information related to supervision of residents with falls. Review of Resident #1's current FL2 dated 01/10/23 revealed: -Diagnoses included Parkinson's disease and major neurocognitive disorder, dementia secondary to Parkinson's disease. -The documented current level of care was assisted living. -Resident #1 was intermittently disoriented and	D 270		

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was semi-ambulatory with the assistance of a walker.

Review of Resident #1's care plan dated 08/15/22 revealed:
-He was ambulatory with a walker.
-He was oriented and had an adequate memory.
-He was independent with toileting, ambulation and transferring.

Review of Resident #1's current care plan dated 12/09/22 revealed:
-The care plan was updated due to a change in bowel and bladder status.
-He was ambulatory with a walker.
-He was oriented and had an adequate memory.
-He required supervision/set up with transferring and ambulation.
-He required limited assistance with toileting.

Review of Resident #1's incident reports revealed:
-Resident #1 had eleven falls between 11/07/22 and 01/11/23.
-All eleven falls were documented as unwitnessed.
-Documented injuries included: skin tears (11/10/22, 11/16/22, 11/29/22, 01/01/23 and 01/04/23), left arm pain (01/02/23), "possible injury to left shoulder"/pain (01/01/23), bump and redness on the back of the head (12/14/22) and pain in the chest (11/16/22).

Review of Resident #1's fall intervention meeting notes revealed interventions for each of Resident #1's falls included: a medication review, a nightlight, consulting physical therapy, wearing grip socks, using a hospital bed, keeping items within reach, providing education on requesting help and/or using the call bell, rearranging his

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bedroom, providing a different chair for his room, providing supervision to and from meals and increasing supervision.

Review of Resident #1's signed physician's orders dated 01/11/23 revealed an order for Resident #1 to be checked on every hour.

Interview with a personal care aide (PCA) on 02/09/23 at 11:30am and 1:30pm revealed:
-All of the residents were checked on every two hours and it was documented in a binder.
-She was trained to check on residents who were incontinent every hour to reduce the risk of skin issues.
-She was trained to monitor residents once a shift for 72 hours after a fall but that did not include checking on them more often.
-The fall monitoring included asking if the resident was in pain, checking the resident for bruising and making sure the resident did not have a changes in physical or mental status.
-Resident #1 had a star above his door because he was at risk for falling.
-She walked up and down the hall constantly and stopped to check on the residents with stars whenever she passed their rooms; however, she was not trained by the facility to do that.
-When she started working at the facility in October 2022, Resident #1 was independent with his activities of daily living (ADL); however, in December 2022 he began to require help with transferring, walking to the bathroom and dining room with the assistance of a walker.
-Around the middle of January 2023, she was informed by a medication aide (MA) that Resident #1 had to be checked on every hour to prevent him from falling.
-Resident #1's hourly checks were documented on his electronic medication administration record

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(eMAR) by the MA.

Interview with a second PCA on 02/10/23 at 1:15pm revealed:
-She checked on residents every two hours.
-She noticed Resident #1's mobility declined at the beginning of January 2023.
-Around the middle of January 2023, a MA told her Resident #1 needed to be checked on every hour to prevent him from falling.
-She did not document Resident #1's hourly rounding but the MA did.

Interview with a MA on 02/09/23 at 1:10pm revealed:
-The residents were checked on every two hours and that was documented in the monitoring book.
-She also checked on residents when she gave medication or offered a glass of water.
-If a resident fell, the MAs would complete documentation on the eMAR related to bruising, pain and a change in mental status or physical condition for 72 hours after the fall.
-That documentation was completed once a shift for 72 hours after a fall.
-A physician's order was required when a resident needed to be checked more than every two hours.
-If a resident required increased supervision, it was documented on the eMAR.
-Around the middle of January 2023, Resident #1 had an order to be checked every hour due to falling frequently.
-Resident #1's hourly checks were documented on the eMAR.

Interview with a second MA on 02/09/23 at 10:35am revealed:
-After a fall, the MAs were responsible for completing an incident/accident report.

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D 270	Continued From page 4 -She did not know what the fall precautions were to implement after a resident fell. Telephone interview with Resident #1's Power of Attorney (POA) on 02/10/23 at 11:24am revealed: -She was aware Resident #1 fell frequently and the facility contacted her after every fall. -She was not aware of any interventions that the facility implemented to prevent him from falling and did not remember being involved in a care plan meeting. -She thought Resident #1 should have been checked on more frequently than every two hours. -The Administrator discussed moving Resident #1 to the Special Care Unit (SCU), since the staff to resident ratios were higher than they were in the assisted living. -She decided against the SCU because Resident #1's medical needs were greater than what the facility was able to accommodate. -She had Resident #1 discharged from the facility on 01/21/23. Interview with the RCC on 02/09/23 at 3:15pm revealed: -Once a week she, the Special Care Unit Coordinator and the Physical Therapist met to discuss residents who had fallen and what interventions could be implemented. -When deciding on possible interventions, they considered what time of day the fall occurred, where the fall occurred and how the fall occurred. -The PCP reviewed Resident #1's fall interventions and agreed with the facility's plan. -All residents were checked on every two hours and an order from the PCP was required to increase their level of supervision. -If a resident fell multiple times, she would ask the PCP for an order to increase supervision.	D 270		

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D 270	Continued From page 5 -She knew Resident #1 fell multiple times in the last three months but she was trying other interventions to prevent falls before asking for an order to increase supervision. -She did not know why she waited until 01/11/23, after Resident #1 had fallen eleven times, to talk to the PCP about increasing his level of supervision. Telephone interview with Resident #1's PCP on 02/09/23 at 4:00pm revealed: -Resident #1 was independent when he was admitted to the facility in August 2022, but he slowly declined. -She was aware Resident #1 fell frequently. -She spoke to the staff about fall precautions which included consulting physical therapy, posting signs in his room to remind him to call for help, assisting him to the bathroom and dining room. -When he started to decline, Resident #1 was difficult to redirect and would use the call bell for certain things, but not every time he needed to get up. -Physical therapy was consulted for Resident #1 on 11/15/22 due to poor balance with bilateral lower extremity muscle wasting and atrophy with multiple falls. -He needed to be supervised more than every two hours due to poor balance, weakness and getting up without asking for assistance. -She did not write an order for increased supervision on 11/15/22 since she observed staff go in his room frequently during her visits to the facility and was not aware the facility required an order to provide increased supervision. -She wrote an order on 01/11/23 for Resident #1 to be supervised every hour due to being out of interventions.	D 270		

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D 270	Continued From page 6 Interview with the Administrator on 02/08/23 at 3:07pm: -Residents were routinely checked on every two hours. -If a resident required increased supervision the RCC would have to ask the PCP for an order. -The PCP's order would allow the facility to document increased supervision on the eMAR and the facility would have a documented reason for the increased supervision. -She was aware Resident #1 fell frequently and that an order to increase his supervision was not implemented until 01/11/23. -She thought an intervention could only be used one time and that it could not be ongoing. -This might have been why the RCC waited until 01/11/23 to implement hourly supervision. _____ The facility failed to provide supervision for Resident #1 who experienced eleven unwitnessed falls in three months which resulted in multiple injuries including skin tears. This failure was detrimental to health, safety and well-being of the resident and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 02/09/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 27, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

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D 273	Continued From page 7 of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to ensure health care referral and follow up for 1 of 2 sampled residents (#6) related to a resident who fell and sustained a head injury. The findings are: Review of the facility's accident/falls policy dated September 2021 revealed an accident was an unexpected, unplanned event which may or may not cause injury. Review of the facility's undated head injury policy and procedure revealed: -A Level 1 accident/injury was considered red and staff were to call 911. -According to Level 1, if the resident sustained a lump or bump to the head or face, or increased confusion the resident was to be sent out to the hospital. -Head injuries could result in bleeding in or around the brain and symptoms may not be apparent at first and may have a more gradual onset after the head injury. -The follow up/monitoring of a resident for 3 days after a head injury included monitoring for signs of a subdural hematoma which may include frequent falls, unusual tiredness, incontinence and confusion. Review of Resident #6's current FL2 dated 01/17/23 revealed: -Diagnoses included dementia, depression, hypertensive kidney disease, chronic kidney disease and hypothyroidism.	D 273		

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D 273	Continued From page 8 -She was ambulatory and constantly confused. Review of Resident #6's Incident/Accident report dated 01/22/23 at 7:05am revealed: -She was found in her room, laying flat on her back, with a knot/bump to her head. -There was no documentation first aid was administered. -At 9:39am, Resident #6's primary care provider (PCP) was notified. -She was not sent to the hospital. Review of Resident #6's progress notes dated 01/22/23 revealed: -At 7:05am, Resident #6 had a fall. -At 9:49am, the PCP was notified an unwitnessed fall in her room entryway, there was a knot on the back of her head with soreness. -At 3:31pm, the Resident Care Coordinator (RCC) documented Resident #6 no pain, no mental status changes, and no new injuries since the fall. -At 4:14pm, the medication aide (MA) documented Resident #6 was in pain, and brusing to the back of the head. -At 4:10pm, the MA notified Resident #6's PCP that her blood pressure (BP) was 152/94 (a normal BP was 120/80). -At 8:58pm, the MA documented Resident #6 no pain, mental status changes or new injuries since the fall. Review of Resident #6's progress notes dated 01/23/23 revealed: -At 4:35pm, the MA documented no pain, mental status changes or new injuries since the fall. -At 10:33pm, the MA documented no pain, mental status changes or new injuries since the fall. Review of Resident #6's progress notes dated	D 273		

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D 273	Continued From page 9 01/24/23 revealed: -At 12:23pm, the MA documented no pain, mental status changes or new injuries since the fall. -At 9:34pm, the MA documented no pain, mental status changes or new injuries since the fall. Review of Resident #6's progress notes dated 01/25/23 revealed at 4:32pm the MA documented no pain, mental status changes or new injuries since the fall. Review of Resident #6's Incident/Accident report dated 01/26/23 at 4:25am revealed: -She was found in her room, laying on the floor beside her bed. -There was documentation she "rolled out of bed". -There was pain to her lumbar back. -There was no first aid administered. -At 4:25am, Resident #6's primary care provider (PCP) was notified. -She was not sent to the hospital. Review of Resident #6's progress notes dated 01/26/23 revealed at 9:23am, her PCP was notified complaining of low back pain. Review of Resident #6's Incident/Accident report dated 01/26/23 at 9:50am revealed: -She was found in her room, laying in her bed in pain. -There was no first aid administered. -At 9:50am, she was sent to the hospital. Review of Resident #6's progress notes dated 01/26/23 revealed: -At 4:25am, the MA documented a fall and Resident #6 was found on the floor. -At 4:36am, the MA documented the PCP was notified Resident #6 had an unwitnessed fall with	D 273		

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no signs of pain or injury.
-At 9:23am, the MA documented Resident #6 reported pain to her lower back.
-At 9:50am, Resident #6 was sent to the hospital.

Review of Resident #6's Emergency Department (ED) report dated 01/26/23 revealed:
-She sustained a ground level fall around 3:30am, was found on the floor by the staff and later complained of lower back pain and a mild headache.
-There were some faint ecchymosis (a discoloration of the skin resulting from bleeding underneath) to the left of the left lateral orbit (a bony cavity in the skull that houses the globe of the eye).
-On 01/26/23, computerized tomography (CT) scan showed no intracranial bleed.
-On 01/26/23, a lumbar spine Xray showed worsening of known T12 compression fracture.
-On 01/26/23, a thoracic spine Xray showed multilevel compression deformities, appearing similar to before.
-On 01/26/23, she was discharged back to the facility with an order to follow-up with orthopedics.

Interview with a MA on 02/09/23 at 10:35am revealed:
-She worked a 12-hour shift, from 7:00am to 7:00pm.
-Prior to 01/19/23, the fall policy was to send a resident to the hospital when a resident hit their head.
-As of 01/19/23, the policy changed and the Administrator and the RCC taught her in the case of a head injury with no blood then the resident was to be monitored every shift for a change in mental status, increased pain, or new injuries found, then notify the physician.
-On 01/22/23, Resident #6 fell, hit her head,

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complained of pain to her head and there was a knot to the back of her head.
-She did not sent Resident #6 to the hospital because Resident #6 was not bleeding.
-Resident #6 was confused
-She monitored Resident #6 for the rest of her shift for changes in Resident #6's mental status, any increased pain or new injuries.

Telephone interview with Resident #6's PCP on 02/10/23 at 9:05am revealed:
-She was aware of Resident #6 falling and hitting her head but she was not informed about the knot to the back of Resident #6's head.
-She instructed the MA to monitor for signs of a brain bleed and to send Resident #6 to the hospital with changes in the resident's mental condition, complaints of new or increased pain,
-She and the facility and had a policy to send all residents with a head injury to the hospital.
-On 01/22/23 around 4:00pm, a MA notified her about Resident #6's BP was a little high and no new orders were given.
-On 01/26/23 around 10:00pm she was notified Resident #6 was sent to the hospital after another fall and complaints of low back pain.
-Resident #6 should have been sent out on 01/22/23 at 7:05am after the fall where she sustained a head injury.
-Resident #6 required a CT of her head to rule out a brain bleed from hitting her head.
-Since Resident #6 was not sent to the hospital on 01/22/23 around 7:00am, then Resident #6 should have been sent to the hospital anytime after that when Resident #6 complained of increased pain, changes in her mental condition such as with confusion and any new injuries noted.

Interview with the RCC on 02/10/23 at 9:30am

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D 273	Continued From page 12 revealed: -She was an Licensed Practical Nurse (LPN). -There was a new head injury policy put in place the Administrator implemented on 01/19/23. -She and the Administrator trained all the MAs on the new policy on 01/19/23. -Per the new policy, a resident who sustained a Level 1 head injury with bleeding was to be sent to the hospital. -If the head injury did not include a lump or bump and the resident was without confusion, and did not lose consciousness at any point, the the PCP was to be notified and the resident should be monitored for 72 hours for symptoms of a brain bleed which included, a change in their mental status, increase pain, frequent falls, and unusual tiredness. -According to the incident/accident report for Resident #6 and the written policy and procedure for a head injury, on 01/22/23 Resident #6 should have been sent to the hospital for a lump to the face or head. -The head injury had to include bleeding before the resident was to be sent to the hospital. -According to the head injury policy and procedure, a resident was to be monitored for changes in mental condition, increased pain, and new injuries noted for 72 hours. Interview with the Administrator on 02/10/23 at 9:45am revealed: -The MAs were responsible for notification to the physician and to send a resident to the hospital for a fall with injuries and/or a head injury with a lump or bump. -There was a new head injury policy she put in place on 01/19/23, from a corporate training she attended the week prior. -She was informed to go back to the facility and begin the training at the facility.	D 273		

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SPRINGS OF CATAWBA	2010 29TH AVENUE DRIVE NE HICKORY, NC 28601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13 -She and the RCC trained all the MAs on the new policy on 01/19/23. -The new policy was that according to a Level 1 injury, a resident who sustained a head injury was to be sent to the hospital. -If the head injury did not include a lump or bump and the resident was without confusion, and did not lose consciousness at any point, the the PCP was to be notified and monitor the resident for symptoms of a brain bleed which included, a change in their mental status, increase pain, frequent falls, and unusual tiredness. -According to the incident/accident report for Resident #6 and the written policy and procedure for a head injury, on 01/22/23, Resident #6 should have been sent to the hospital for a lump to the face or head. -She was not aware Resident #6 was not sent out to the hospital on 01/22/23. -The RCC was responsible for daily audits of the incident/accident forms and resident progress notes to check to make sure a resident was sent to the hospital after sustaining a head injury or within the 72 hours displayed a change in mental status, increased pain or new injuries. -She was not aware that was not completed or the RCC would have sent Resident #6 to the hospital anytime after 01/22/23 up until 01/26/23 at 9:00am. _____ The facility failed to ensure Resident #6 was sent to the hospital for evaluation after she fell and sustained a knot to the back of her head, resulting in increased pain, another fall resulting in worsening of spine compression fractures (#6). This failure resulted in substantial risk of serious injury, abuse, neglect, to all residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018032	A. BUILDING: _____ B. WING _____	C 02/10/2023

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D 273	Continued From page 14 accordance with G.S. 131D-21 on February 10, 2023. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2023.	D 273		